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ABSTRACT

This guide is designed to be a resource for individuals and agencies wishing to provide health promotion programs for rural black elderly. Community health promotion is defined as "any combination of educational, social, and environmental supports for behavior conducive to health." Part One, "Health Promotion and the Rural Black Elders," introduces health promotion concepts, the health problems and behaviors of the rural black elderly, and factors that influence black elders' attitudes toward and participation in health promotion. Part Two, "Planning a Health Promotion Program," discusses the steps in building a program, and develops a framework for culturally relevant health promotion programs. Part Three, "Health Promotion Delivery Techniques," offers specific examples of techniques that have been used by practitioners across the country to encourage involvement by rural black elderly in health promotion programs and to make the programs more culturally relevant to participants. Contains 49 references, a health style self-test, a list of resource centers with descriptions, and a list of resource materials with ordering information. (KS)

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Center on Rural Elderly

Health Promotion for the Rural Black Elderly:

•A Program Planning and Implementation Guide

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Health Promotion for the Rural Black Elderly: A Program Planning and Implementation Guide

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INTRODUCTION

While health promotion for the elderly has received increasing attention and support in recent years, few programmatic efforts have been directed toward the rural black elderly population. Efforts made to include rural black elders in health promotion activities have sometimes been frustrated by inappropriate methods on the part of program planners as well as by some of the unique circumstances of the target population.

As expressed by Joseph L. White in The Psychology of Blacks: An Afro-American Perspective (1984), "... there is a distinctive, coherent, persistent Afro-American psychological perspective, frame of reference, world view, or cultural ethos that is evident in the behavior, attitudes, feelings, life styles, and expressive patterns of Black Americans." Transmitted from one generation to the next, this world view "... provides people with a way of interpreting reality and relating to others and a general design for living."

This guide is designed to serve as a resource to individuals and agencies who wish to provide health promotion programs for rural black elderly. To assist in meeting the needs of this population, the guide provides the following:

- general concepts and goals of health promotion as it relates to rural blacks.
- an overview of particular conditions and needs of the rural black elderly which must be considered when planning programs.
- necessary components of a health promotion program as well as ways in which program delivery should be adapted for rural black elders.
- examples of successful techniques that have been used by others in the delivery of health promotion programs.

Part One, "Health Promotion and the Rural Black Elderly", contains six sections. Two of these serve as an introduction to health promotion. The remaining four address the health problems and behaviors of the rural black elderly and factors which influence black elders' attitudes toward and participation in health promotion.

Part Two, "Planning a Health Promotion Program" contains detailed sections that are useful once a program planner sensitized to the unique needs of the rural black elders, begins to prepare a specific health promotion program. The steps necessary to building a program for this population are discussed and a framework for culturally relevant health promotion programs is developed.

Part Three, "Health Promotion Delivery Techniques," offers specific examples of techniques that have been used by practitioners across the country to encourage involvement by rural black elderly in health promotion programs and to make the programs more culturally relevant to participants.

Black elderly, like the elderly in general, are a varied group. Differences exist due to geographical location, age, income, education, and residence. According to 1980 U.S. Census data, there are approximately 2.1 million black elderly. Twenty percent (420,000) of the black elderly reside in nonmetropolitan areas, and three-fifths of older blacks reside in the South. The highest concentrations reside in Georgia, Louisiana, Alabama, North Carolina and Mississippi (Parks, 1988). For the **rural** black elder population, the largest concentration live in the South. In light of these figures, the contents of this guide will largely address Southern black culture. This does not limit the applicability of the guide to rural blacks living in other parts of the country, but only serves as a reminder that information was included in light of its relevance to the needs of Southern rural black elderly.

It is important to emphasize that, even within the target population of rural black elders, there is considerable variation. Thus, one is cautioned to remember this "diversity within" in using the information from this manual with any group.

Where possible, data on rural black elders have been presented. In some cases, statistics were not readily available for this population and therefore information on the black elderly as a whole are used. It is important for the reader to recognize that the characteristics of rural black elders may deviate somewhat from the demographics of black elders in general.

This guide is designed with the widest possible applicability in mind. Therefore, not all parts or sections will be relevant to all readers. A strict outline for a specific health promotion program designed for rural black elders is not attempted here. Rather, the guide provides more basic information that will be useful to readers from different backgrounds with varied levels of expertise. The reader may be interested in the general issues of health promotion for rural black elders, or in a specific type of intervention. The guide may also prove useful to others who are providing services to rural black elders outside of the realm of health promotion. The guide is designed to be used as a resource, with sections taking on importance as they become applicable to the reader's own circumstances.

PART ONE

HEALTH PROMOTION

AND

RURAL BLACK ELDERS

Overview of Community Health Promotion

Over the past decade, there has been considerable growth in health promotion for older adults. This growth has been in concert with the overall health movement for all age groups, although health promotion programs initially excluded older populations (Teague, 1987). Initial programs were developed for urban audiences; however, recently programs have been developed for rural elderly audiences (Bender and Hart, 1987; Lubben, Weiler, Chi and De Jong, 1988). Health promotion for black elders, whether urban or rural, has not been emphasized (Haber, 1986).

There are several reasons to focus attention on health promotion for black elders, with emphasis on the rural population. Elderly blacks, as well as the minority elderly population in general, are increasing at a faster rate than elderly whites, and this trend is likely to continue well into the next century (Soldo, 1988). In addition to demographic trends, other factors point toward the need to focus health promotion efforts on this group. Problematic areas for both rural and black elders such as lower health status including chronic illnesses, lack of access to and use of health care services, and socioeconomic and cultural influences on health education and health care utilization (Coward and Lee, 1985; Jackson, 1988; Krout, 1986) strongly suggest that rural elderly blacks indeed can be doubly disadvantaged and thus are prime candidates for health promotion programming.

Health promotion programs are very diverse in both content and intervention strategies. For the purposes of this guide, **community health promotion** is defined as: **"Any combination of educational, social and environmental supports for behavior conducive to health"** (Green and Anderson, 1982). Educational supports may be directed at high-risk persons, families, or groups as well as at the entire community. An important focus of health promotion is the health behavior of the entire community, which includes the actions of both the people whose health is in question as well as the community decision makers, professionals, family, peers, and others who may influence health behaviors, resources or services in the community (Green and Anderson, 1982).

Health promotion programs recognize that the health of individuals is influenced by **voluntary personal behavior**, heredity, economics, and their social environment. Successful health promotion programs recognize the importance of **self-responsibility**. Personal health is significantly improved by individual actions such as exercise, proper diet, stress management, and accident prevention. (Fallcreek and Mettler, 1984).

disease prevention and treatment activities for individuals within the Maywood community, as well as mechanisms to increase community-based curricular content in the professional schools.

After several months of joint planning, a co-sponsored community and academic health center invitational conference was held in May of 1992. A request for the funding to support an invitational conference within the Maywood community was submitted to the federal Agency for Health Care Policy and Research (AHCPR) and approved but not funded, consequently, support for the conference was subsequently provided by Loyola, with Maywood contributing the site facilities. The primary Loyola initiators of this effort were principal SSOM and MNSON administrators. They worked in collaboration with the Mayor of the Village of Maywood and were conveners of a joint planning committee composed of community-identified leaders, academic health center faculty and staff, and representatives of the Cook County Health Department to plan the conference. The overall conference goal was to bring together community and AHC experts in the areas of HIV/STD, Hypertension/CAD, Substance Abuse, and Maternal and Child Health issues such as Teen Parenthood with the outcome of articulating a health agenda for the Village of Maywood.

The conference opened with a welcome from the Provost of the AHC and the Mayor of Maywood. Participants from Loyola included the Deans of Medicine and Nursing, the Assistant Dean of Nursing and the Senior Associate Dean of Medicine, Department Chairs from both medicine and nursing, the Chief of Staff, and faculty from both medicine and nursing. Maywood attendees included Village Trustees, the President of the Chamber of Commerce, and leadership and representation from major social service agencies in the community, including the Cook County Department of Public Health (CCDPH), and community residents including several teens from the area high school.

An outcome of this conference was the identification of an action agenda in the prevention and treatment of substance abuse, sexually transmitted diseases, HIV infection/AIDS, teen pregnancy, and hypertension. The structure that emerged from the conference consisted of a steering committee composed of the joint planning committee with additional members and five task forces. Each of these task forces is co-chaired by representatives from Loyola, Maywood, and the CCDPH. Each has the goal to identify strategies to refine and promote the action agenda for their area that was articulated at the conference. Recently, Loyola has received funding from the Pew Charitable Trust, Robert Wood Johnson and Rockefeller Foundation's Health of the Public program as one of 28 academic health centers for the project entitled "Healthy Teens for the Year 2000".

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- nutrition
- medication education
- consumer education
- safety
- mental health (including stress management)
- physical health (including exercise)
- other health issues (including alcohol abuse, drug abuse, and AIDS)

Overview of the Rural Black Elderly

Health Status

There is considerable evidence, regardless of the measurement of health status used (i.e. self-assessment, reports of ailments and mobility limitations, use of health aids or prescription drugs, or number of days hospitalized), that rural elderly are in poorer physical health than their urban counterparts (Krout, 1986; Lassey and Lassey, 1985).

Less clear are differences in health status between black and white rural elderly. There is some evidence that, compared to whites, rural black elders have higher chronic illness rates (Lassey and Lassey, 1985). **Diabetes** in particular, is much more prevalent in older black than in older white populations. Black elders have an approximately 55% higher rate of diabetes (Type II or adult diabetes) than do whites of the same age group (Chart 1) (Lieberman, 1988). While not broken down by place of residence, three-fifths of the black adult diabetic population 65 and over reside in Southern states where the highest proportion of rural elderly blacks reside (Parks, 1988). Thus, relatively more older blacks have diabetes than older whites and a higher proportion of these older blacks live in Southern, predominantly rural areas.

HEALTH STATUS:

Rates of Diabetes and Hypertension (per 1,000):
Ages 65 - 74

Chart 1.	Rates of Diabetes	Chart 2.	Rates of Hypertension
	Blacks: 129.3		Blacks: 440.0
	Whites: 83.4		Whites: 331.0
	Blacks: Whites = +55%		Blacks: Whites = +33%

Hypertension is frequently considered the number-one health problem among blacks. Blacks are roughly twice as prone to develop hypertension as whites, and this likelihood increases with age (Chart 2) (Anderson, 1988).

Cancer, one of the leading causes of mortality for both rural and urban elders (Lassey and Lassey, 1985), is disproportionately a burden within black populations where incidence rates are highest in comparison to eight racial/ethnic groups, including whites (Baquet, 1988). When compared to whites, black males (who are particularly at risk) have the highest rate of incidence of all cancers until age 75 and the highest rate of mortality for all cancers up to age 70-74 (Baquet, 1988).

Other conditions affecting elderly blacks include obesity, which is prevalent among older black women (Lieberman, 1988), and musculoskeletal disorders, which are more prevalent among older rural black men than among older urban black men (Lassey and Lassey, 1985).

In summary, available information suggests that rural elderly blacks are at a greater risk than their white counterparts for chronic illnesses such as diabetes and hypertension, and for diseases such as cancer.

Health Care

There is considerable documentation that rural areas, in comparison to urban areas, have fewer health care services and a lower ratio of doctors, nurses, pharmacists and other health care personnel (Krout, 1986; Lassey and Lassey, 1985). For older rural blacks, access to health care services may be even more problematic. A 1988 study of rural elderly blacks in Arkansas, Tennessee and Mississippi found that 47% did not have a doctor in the community where they resided and that, on average, individuals had to travel 10.7 miles to see a family doctor and 20.1 miles to see a dentist (Parks, 1988). This lack of availability of health care is coupled with transportation difficulties, a common problem in rural areas (Krout, 1986; Lassey and Lassey, 1985).

Predisposing Factors

Predisposing factors are identifiable characteristics attributed to a person that are likely to increase the possibility of him/her utilizing existing services that will lead to better health. The major factors include demographic characteristics of the population (education, marital status, sex), belief systems, values, and attitudes which affect black rural elders' health behaviors and health status. The usefulness of predisposing factors in understanding the rural black elderly population is the

presumption that some individuals have a greater likelihood of utilizing services than do others and that this fact is related to certain background characteristics of the individual.

Education

Educational level as well as educational participation of rural black elders can influence health promotion programming for this group. In general, older blacks have lower educational levels and corresponding literacy levels than older whites. Eighty percent of black men and women 65 years and over have not completed 9th grade and 40 percent have completed less than 5 grades (Heisel, 1984). Moreover, education per se may not reveal true educational attainment. Intermittent education due to lack of educational facilities as well as family and work responsibilities may affect the literacy levels of older blacks, even if educational level would indicate otherwise.

Although rural black elderly may have lower educational levels, their belief in education as a means of improving one's life economically, politically and socially reflects historically a value orientation in African American culture (Anderson, 1988; Franklin, 1984). Studies of educational participation of older blacks have indicated that this group shows an interest in educational activities (Heisel, 1985; Ralston, 1983); has participated in self-directed learning, although at lower levels than whites (Ralston, 1983); and has been receptive to other types of educational programming when their cultural and socioeconomic needs are taken into account.

Cultural Health Practices

There is little doubt that cultural patterns of rural black elders play an important role in their health promotion. To some elderly blacks, particularly those in isolated rural areas, illnesses can be categorized into different types, depending on the perceived source of the illness. These include natural illnesses which have physical causes, occult illnesses which result from supernatural forces such as evil spirits, and spiritual illnesses which result from willful violation of sacred beliefs or sin (Watson, 1984). There is a close relationship between the presumed cause of an illness and the type of practitioner and treatment needed. For example, medical doctors or herbalists might be consulted for physical processes, but conjurers would be needed to expel evil spirits in occult illnesses and religious healers would be called upon for spiritual illnesses.

With these beliefs and resulting health practices, rural black elders are sometimes not understood by professional health care workers. One example is the cultural-

bound syndrome of "falling out" which is of sudden onset and usually occurs in a highly emotionally charged situation or environment (Carter, 1988). Symptoms include frequent twitching of both small and large muscle groups, but no convulsion and no bowel or bladder incontinence. When presented to a health care worker, these symptoms can only result in puzzlement and often an incorrect diagnosis. Another unique characteristic is the belief in the medicinal properties of herbs, ointments and lotions, and the sometimes excessive use of laxatives or oils, primarily due to the preoccupation with constipation. This use of over-the-counter drugs can lead to "drug misuse" (Primm. 1984), and those involved in providing health promotion programming will need to be aware of this possibility in planning programs with medication information and safety precautions for older blacks.

Cultural influences also extend to diet and food practices of rural black elders. Food preferences, characteristic of blacks in general and particularly important to older blacks who often are the "keepers of knowledge" on the selection and preparation of foods, are high in fat and cholesterol. Although the dietary patterns of blacks are not much different than those of whites, the uniqueness is in both the method of food preparation (e.g., frying and barbecuing meats, use of hot sauce and black pepper) and the selection of foods (e.g., hot breads, chitterlings, ham hocks, hominy grits, blackeye peas, greens) (National Dairy Council, 1988). These and other dietary patterns (e.g., low milk consumption) along with lifestyle preferences (e.g., meal skipping) can result in some nutritional inadequacies (Jerome, 1988).

Beliefs, Attitudes and Values

There are many different beliefs and values which affect health behaviors. Understanding these cultural influences can help one be more effective in reaching out and serving this population. Just as there are variations among elderly Blacks in terms of health status and demographic characteristics, there are also differences in the degree to which they have retained or endorsed certain cultural beliefs.

Program planners will do well to be sensitive to prevalent cultural beliefs and learn the differences in the individuals with whom they come in contact. Awareness of these cultural differences is only part of the task of the health educator. Respect for these beliefs and acknowledgement of their legitimacy is an important step in gaining the trust and respect of those with whom one is working.

Elderly blacks, like other elders, vary in the degree to which they believe they have control over health and illness. Some are fatalistic, believing that illness and health are out of their control. The strong role of spirituality in the lives of these elders affects the perceived degree to which they have control over the outcomes of illness. A religious individual might believe that health is in the hands of God and that

suffering must be accepted in order to be a good Christian. Programmers are more likely to attain their goals by recognizing these beliefs and utilizing them as a basis for building a sense of self-responsibility for one's health.

Informal Supports

It is generally well-recognized that elderly individuals are not isolated from their kin, but rather are members of modified extended families. Rural elders are similar to urban elders in informal support networks (Krout, 1986; Lassey and Lassey, 1985; Mercier and Powers, 1984). Both groups have family (spouse, children, and children's family), friends, and neighbors as part of their support network and, to a lesser degree, extended family such as siblings, grandchildren, and other distant relatives. However, rural elderly more often live with a spouse, have male-headed households, and have fewer children living in the same community (Krout, 1986; Lassey and Lassey, 1985; Mercier and Powers, 1984).

Older blacks tend to be more versatile in utilizing both family and friends while whites are more likely to limit help-seeking to spouses in middle life and to replace spouses with a single family member in old age (Gibson, 1982). Black families appear to be more involved in exchanges of help across generations and, older blacks in comparison to older whites, give more help to children and grandchildren (Taylor, 1988). Non-kin become "relatives" through child fosterage and adult adoptions and these relationships create ties which result in certain rights and obligations, including care of the aged family members (Shimkin, et al., 1978). Terms such as "play mother" are used and suggest the function as well as the nature of the relationship.

Assistance with health care appears to be one of the many functions of the informal network among black elders. In contrast to elderly whites, whose network of kin and non-kin expands as the level of disability and the need for health care increases, informal network size and composition for black elders is not affected by health factors (Chatters, et al., 1985, 1986). Church members play a significant role in the informal networks in general, and health care assistance in particular. Action usually taken to help an ill church member often includes giving money or taking up a collection, visits, prayer, and gifts (Parks, 1988).

Formal Supports

It is commonly known that service provision and utilization is more problematic in rural areas (Coward and Rathbone-McCuan, 1985; Krout, 1986). Older blacks traditionally have been lesser users of services in comparison to older whites. Rural black elders do not appear to be frequent users of formal services, and depend

more on their informal network for assistance. Although there are many reasons for low rates of service use by elderly blacks, particularly those in rural areas, lack of access (i.e., scarcity of programs, lack of transportation), institutionalized racism, poor treatment, and past experiences of promises not kept are generally seen as some of the underlying reasons (Dancy, 1977).

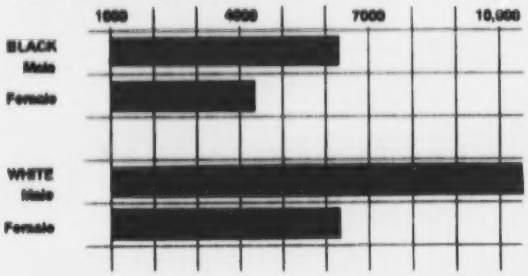
Enabling Factors

Even though individuals may have varying tendencies to use services, they will not actually utilize them unless they have some means for doing so. The means for the acquisition of services are known as enabling factors and include such variables as socioeconomic status, structural barriers, and culturally insensitive resources. For example, costly services are out of reach of persons living economically at the margin; services that require the ability to read and fill out forms are unattainable to those unable to do so; or complex eligibility requirements of specific agencies will preclude persons unable to understand these requirements.

Socioeconomic Status

Compared to elderly whites, black elders have disproportionately lower incomes. In 1984, the median income of black males 65 and over was $6,163, approximately 57% of the median income ($10,890) of white males 65 and over. For the same year, the median income of black females 65 and over was $4,345, or 69% of the median income ($6,309) of white females 65 and over (Manuel, 1988). The median income of families headed by individuals 65 and older was equally disproportionate. For blacks, the median income was $11,983, 64% of that of whites ($18,775) (Chart 3) (Manuel, 1988).

SOCIOECONOMIC STATUS

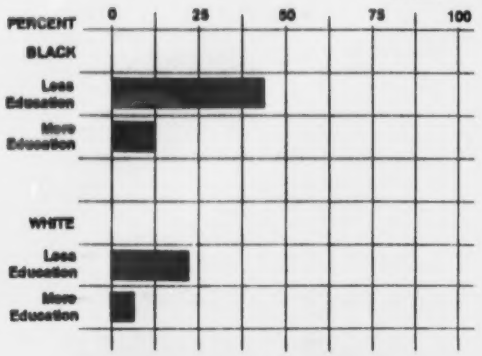


INCOME BASED ON 1984 RECORDS

Chart 3

65 years and older

Chart 4



LIVE BELOW POVERTY LINE

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Poverty rates also provide insight into the economic burden of black elders. For 1984, 31.7% of the black elderly lived below the poverty line as compared to 10.7% of white elderly (Manuel, 1988). While lower levels of educational attainment could be expected to account for some of this disparity, analysis of the same data with the effect of education removed found that for black elderly with an elementary level of education or less, 45.6% were below the poverty line. This compared to 19.7% of white elderly. For those black elderly with college education of 5 or more years, 10.1% were beneath the poverty line, as opposed to 4.9% of white elderly with similar educational background (Chart 4) (Manuel, 1988). Black elders, then, are still twice as likely to live in poverty, regardless of educational experience. One partial explanation for this discrepancy may lie in the occupational backgrounds of this cohort of elderly blacks. Discriminatory practices in employment and hiring have forced many elderly blacks to work in menial jobs during their prime working years compared to whites with comparable educational backgrounds.

Structural Barriers

Simple logistical problems may play a role in the black elder's willingness and ability to utilize existing services and resources.
These include:

- **lack of awareness of available services**
- **lack of private transportation**
- **lack of public transportation available in rural areas**

For those with physical disabilities, lack of access to facilities can be a barrier. Family obligations may limit the elderly individual's ability to take advantage of programs if he/she is the primary caretaker for a frail spouse, a relative, or the regular babysitter for family members' children. Without respite or child care opportunities available, the elderly individual will find participatior difficult.

Culturally Insensitive Resources

A black elder's resistance to utilizing services or programs may be due to perceived cultural insensitivity on the part of agency personnel. The black elderly have a long history of interaction with various agencies and professional personnel. For the majority of these elders, discriminatory attitudes on the part of staff may have been encountered (Dancy, 1977). The black elder who has experienced repeated racism

may be likely to perceive that such attitudes are still present and will avoid using needed services regardless of whether such discrimination is or is not present (Downing and Copeland, 1980).

A common view is that this cultural insensitivity in service agencies could be eliminated by having adequate numbers of minority staff in key positions. However, black agency staff and health care workers have traditionally been under-represented in the aging network. This discrepancy becomes more critical in light of a survey done several years ago which found that 60% of gerontology graduate students indicated they needed some knowledge of minorities in their anticipated fields (Hartford n.d.). A survey of curricula content further indicated that little content was provided to highlight minority aging in courses which were designed to prepare practitioners (Davis, 1974).

Another complicating factor is the monocultural view in most health promotion materials. To date, formally developed health promotion programs have largely been "generic" in their orientation, and the content and delivery strategies reflect more mainstream (white, middle class) older adult audiences (Ralston, 1989). Thus, service providers who may have a general sensitivity to older black populations have few resources to turn to for help in programming for this audience. The lack of culturally appropriate materials and resources that accompany such programs may indirectly inhibit some black elders from participating in health promotion activities, and make less than meaningful those materials that are in fact incorporated into minority health promotion activities.

PART TWO

PLANNING A HEALTH PROMOTION PROGRAM

20

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Once a commitment has been made to provide health promotion programs, the initiator must plan the specifics of organizing and implementing the program. In this section, a basic model for health promotion educational programs is presented which outlines the steps necessary to providing a program that will be applicable to the conditions of rural black elders as well as being effective. A sincere effort to include all of these steps in one's program will greatly enhance that program's chances for success.

Predisposing and enabling factors which often emerge as barriers to participation were addressed in Part One of this guide. In Part Two, ways of overcoming some of these barriers will be addressed.

As a part of successful health promotion programming, extensive attention is given to the processes of outreach and building a community network. It is the belief of the authors of this guide that a health promotion program which is culturally relevant and has a high rate of active participation will, by definition, have an extensive outreach component. Self-responsibility and empowerment are not limited to health promotion and health behaviors. Individuals have the responsibility, as well as the right, to help direct health promotion and health education programs that are intended to influence them. Involving the target population in the entire process of providing a program is a necessary step in achieving an appropriate and enduring program. Programming experience has yielded the principle that **people are more eager to adopt behavioral changes when they participate in determining those changes, including why they should be made and how they will be implemented.** From the beginning stage of programming — the planning process — persons with the problems, persons committed to solving the problems, and persons who can provide support and assistance in the programming effort need to be actively involved to achieve maximum program results.

Step 1: Do a Community Analysis

It is important to collect information which helps provide an understanding of the community to be served. Much of this information is general background about the black elderly who live in the community. Some of the data to be gathered include the following kinds of information:

- What is the size of the rural black elderly population?
- What are the age and sex demographics?
- What is the general health status of the group?
- What is the average income?
- What is the average level of educational attainment?

- What is the household composition? Are the majority of individuals married? Do they live alone or with family members?
- What diseases are most common in the community (the morbidity rates) and what are the most common causes of death (the mortality rates)?
- What kinds of social activities are most common in the community?

The program planner will also want to obtain information about the organizations and agencies which provide services in their locality. Not only will this help to identify programs that may already be targeted toward this population, it will serve to highlight individuals the planner may wish to include as part of a community network. Such people can be immensely helpful in identifying avenues of local agency cooperation in a health promotion effort.

Information about local agencies/organizations and about the health status of the local population can be obtained from a variety of sources, both within and outside the community. Within the community, social service agencies such as Area Agencies on Aging will have detailed knowledge of the local elderly population. Health information may be obtained from the State and County Public Health Agencies, local hospitals, or other health organizations such as the Visiting Nurses' Association. State Departments on Aging and other agencies may also have access to general information about the target population. One may also wish to utilize public libraries for their U.S. Census data or contact individuals at colleges or universities in the area.

Step 2: Build a Community Network

Building a network within the community is a vital part of planning and implementing a program. The network one builds will help provide information on the community structure and the target population. It can also assist in the process of outreach to rural black elders by planning utilization strategies which lend legitimization to the program.

The network one develops will be more likely to succeed if it consist of key individuals within the community from a variety of backgrounds. These may be individuals who work for agencies and organizations that provide services to the elderly, representatives from organizations respected by the black community, members of the target population, prominent civic leaders whose participation is an indicator of community support, members of the clergy, and other locals who can lend credibility, legitimization, resources, and/or effort to the initiative.

Some of these organizations and individuals may be familiar through their past history of work within the community or through the community analysis initiated in Step 1. By drawing from those individuals who are known to be a source of

information for other "movers and shakers", the network will be broadened and more support created. If possible, ask that they arrange a personal introduction.

For those programmers unfamiliar with the community, approach organizations and individuals slowly. Provide them with general information about health promotion programs and their value to the community and local residents. Indicate a willingness to be receptive to their ideas and a desire to maintain contact with them. Learn as much as possible before contacting organizations and their representatives. Demonstrate knowledge of their priorities and indicate that while a particular organization may not be involved in providing health promotion services to the local rural black elders, it is still valuable to the process of getting the program integrated into the community. Knowledge of the power structure within organizations can prevent approaching inappropriate individuals.

Some of the key types of organizations to contact include:

- Local service agencies
- Governmental leaders
- Churches
- Media representatives (have the local newspaper write an article)
- Fraternities and sororities
- Civic and voluntary groups
- Fraternal orders (Such as Masons or Eastern Star)
- Older adult organizations (Such as AARP or Senior Centers)
- Health care facilities (Health clinics, hospitals, pharmacies, visiting nurses' association, etc.)
- Businesses frequented by the target population (Such as funeral homes, barber shops and beauty parlors, markets)

Though difficult to identify through any particular organization, individuals in professions and occupations may emerge as "key" persons within the community. These can include ministers, nurses, physicians, or retired professionals such as teachers. One way to identify these and other key individuals is through the social and church news of local newspapers. Regular reading of the local paper may reveal that certain active individuals receive regular mention. These types often turn out to be some of the **key** persons.

After beginning the process of establishing contacts with certain organizations and individuals, the process of building an advisory and/or planning committee can begin. As with the community network in general, the advisory committee will be more effective if representatives are selected from local service agencies and organizations respected by the black community, members of the target population and other

prominent community leaders. The advisory committee can assist in all the steps in developing a health promotion program and in establishing outreach to the potential participants.

It is important to maintain regular contact with the individuals and organizations in the community network. In some cases, collaborative agreements with organizations may already exist, and regular contact will thus be automatic. With others, regular informational meetings (personal visits at least twice a year) to update them on the program's status need to be arranged. These meetings will also serve as an opportunity to thank individuals for their cooperation and may lay the groundwork for future programs and cooperative efforts.

Step 3: Do a Needs Assessment

Once the program planner has developed a profile of the local rural black elderly population and community, and laid the foundation for outreach to the target population through community networking, he/she will want to get more detailed information about the needs of the population. Only after a "needs assessment" is it wise for the program planner to select which types of programs to offer. Some of this information may have been obtained through the community analysis. It is helpful, however, to enhance the demographic and statistical knowledge about the problems of the target population through more personalized information gathering.

Interviews and/or surveys of the elderly themselves are among the most useful ways to gather personal information about the target population. This process can be supplemented by interviews and/or surveys of other key informants: agency personnel and community leaders. Although statistical information may reveal that hypertension is a serious problem in the community, an intervention program will have no impact if hypertension is not perceived as a problem by the target population. To make an impact on the community a planner might consider a broad-scale public information campaign as a part of the health promotion effort.

Interviews with elders, as well as with key informants, can also be helpful in understanding why existing programs or services are not being utilized. This type of information will prove invaluable in designing a successful program.

In addition to surveys or personal interviews, other methods for obtaining needs assessment data include community forums, focus groups, and ongoing meetings of the advisory committee. An advantage of these methods is that they allow for interaction among the participants. While consensus may not be reached, group efforts will serve to validate information obtained through other, more individual, sources. The community networking process will also be strengthened as key

organizations and individuals see that their continued input and advice is sought and utilized.

While each focus group or community forum will be individualized to the specifics of the community, a general listing of agenda items includes the following:

a. General introduction to the purpose of the meeting and what will be accomplished. Explanation of the value of community participation to assure coordination of programs and services and optimal participation by the target population in intervention strategies.

b. Introduction of each participant and his/her background.

c. Presentation of the data collected regarding the needs of the local rural black elderly.

d. A discussion by the group regarding the validity of the perceived needs.

e. A brief description of what services or programs are currently available.

f. A description of the types of programs that the program planner sees as valuable in addressing unmet needs.

g. A discussion of the group's reaction to the alternative program possibilities.

h. Concluding remarks by the program planner summarizing the discussions, thanking them for their efforts and emphasizing that their input will be considered in future decisions. It is important to make clear to the group that their role, while important, is advisory. If the participants understand that their advice will be taken into consideration with other information and pragmatic concerns, they will be less likely to be offended if programmatic decisions are made which do not reflect all of their recommendations.

By compiling all the information gathered from the needs assessment, most of the following questions can be answered:

What are the needs and interests of rural black elders in this community?

- Are there certain conditions and illnesses for which they are at high-risk?

- Are these needs perceived as high priority by the elders themselves? (Or, how do they perceive their own health status?)
- In what potential health promotion activities have they expressed an interest?
- What medical, self-help, or other practices do they use to address these problems?

What programs are available?

- How are other agencies and organizations addressing these needs?
- Do the rural black elderly participate in these programs? If not, why not?
- What are the implications for success or failure of a specific health promotion program, based on the history of efforts to operate that program in other settings?

Where should programs be offered?

- Where do rural black elders congregate? In what activities do they participate?
- Where are programs offered by other organizations and agencies? How has location affected the success or failure of these efforts?
- What facility requirements are essential for the target audience to participate (for example, handicapped accessible, on-site child care or respite services, building located within the participants'neighborhood)?

How should programs be offered?

- What are the transportation needs of the target population?
- Is cost a factor in participation?
- Is grandchild care needed? Can volunteers be utilized?
- What personnel and facilities are available to deliver the program?

- What are other barriers to participation?

How should the program be promoted and how can outreach be accomplished?

- What agencies do rural black elders trust and utilize?
- What businesses and organizations do they utilize (churches, senior centers, funeral homes, laundromats, grocery stores, clinics, pharmacies, fraternal organizations, beauty salons and barber shops, etc.)?
- Where and from whom is health information obtained? What media do they use (family members, church leaders and members, community leaders, tv and/or radio, newspapers, etc.)?

Step 4: Program Plan Development

Once the needs assessment process has been completed, the focus shifts from "what *are* the needs?" to "how can we *address* those needs?" Conceivably, the needs assessment will reveal a variety of unmet needs. To help with the decision of setting priorities for the needs and selecting the most appropriate type of health education program to implement, the program planner will want to assemble a planning group consisting of some of the advisory group members. It is crucial to include participants in this planning process, since their involvement can lead to their gaining a sense of ownership in the program, which is a key to success (i.e. changed health behaviors).

There are several processes the planning group needs to consider in developing a program plan. These include developing goals, defining objectives, identifying the resources necessary to carry out the program, and selecting the methods to be used in the program.

Goals are general statements of what the health education is designed to accomplish. For a black elderly population with a high incidence of hypertension, the goal might be stated as:

> **"Educate the rural black elderly population about high blood pressure and control of hypertension."**

The next process involves establishing objectives for the program. Objectives are more specific statements which indicate a desired change and how that change will be measured. The objectives may also include a time frame for achieving that

change. If hypertension is the addressed need, a sample objective might be worded:

> **"Ninety five percent of all participants will be able to identify '140 over 90' as high blood pressure."** Or, **"Ninety percent of all participants will be able to identify the high sodium foods from a list of foods presented to them."**

The program planner will also want to consider the resources necessary to carry out the health promotion program. These will be dictated by the ideals set forth in the goals and objectives, as well as the constraints on the program planner. Staffing needs, financial resources, and time constraints will all affect the resources necessary to carry out the program.

Finally, the program planner will select the strategies and methods for carrying out the program. These strategies will be dictated by the objectives and the resources available for program implementation. The program planner may want to develop a list of alternatives and evaluate the resources and requirements of each program option before selecting the method to be used by asking some basic questions:

- What are the staff requirements (professional, volunteer, lay) to implement this program?
- What funds are necessary to start and maintain this program? If current sources are not sufficient, are there other means for obtaining sufficient funds (cooperative efforts with other agencies or organizations, private grants or donations, fund-raising efforts)?
- What facilities, materials, and equipment will be required to operate this program?
- Will this program avoid duplication of other agency or organization efforts?
- How will success of this program be measured?
- Is this program's objectives consistent with the demographics of the target audience, i.e. their education level, family composition, income, etc.?

Step 5: Implement the Program

Once the health promotion strategy has been selected, the next step is to develop a plan for delivery of the program. This plan should indicate the tasks and activities that need to be carried out before the program can proceed, the time frame for accomplishing these tasks, and who will be responsible for these tasks. Before the program planner can actually implement the program, he/she will need to do the following:

- Identify the activities necessary for carrying out the program methods. These might include selecting a facility; developing; buying or otherwise obtaining curriculum materials; lining up guest speakers; training course leaders; arranging transportation for participants; and marketing the program.

- Assign responsibility for each task to self or other staff and community volunteers and set deadlines for when these duties need to be accomplished.

- Determine the resources required to implement this program and acquire them. These might include audio/visual equipment, handout materials, door prizes, volunteer and participant recognition certificates, and miscellaneous office supplies.

- Develop an evaluation plan (See Step 7: Evaluation).

Step 6: Outreach/Program Promotion

In order to get rural black elders to participate in the program, an outreach effort needs to be developed. The potential participants need to be made aware of the program, conveying to them in ways they can understand, the significance of the program to their lives. **Promotion of the program should ideally consist of both formal and informal strategies.**

- Formal strategies consist of impersonal communication such as advertisements in the media, public service announcements, posters or displays, and leaflets or brochures.

- Informal strategies are personal contacts (including face-to-face contact), community meetings and open houses, letters, fliers, endorsements by prominent community members, and word-of-mouth.

A successful outreach plan consists of a variety of strategies, but within rural communities and the more informal black community, **personal contacts** are more credible than **impersonal messages**. This is a major reason why establishing a sound community network is invaluable. Endorsements by and cooperative efforts with respected local leaders and institutions will encourage participation much more than will formal advertisements placed in local newspapers.

Among the most valuable organizations to involve in outreach efforts to the black community are churches. Historically, the church has played a vital role in the lives of blacks. A review of by Taylor (1988) of the research indicates that within black communities 40% attend services weekly or more, nearly two-thirds are members of churches, and 78% pray daily. Studies further indicate that religiosity of blacks tends to increase with age and that rural blacks are more frequent attenders of religious services than urban blacks (Taylor, 1988).

The church has a prominent position as a gathering place and source of unity in the rural black community. Minimally, the program planner will want to inform local churches of the health promotion program. Ideally, contacts will be made that will encourage the church to:

- promote the program through church bulletins and personal messages
- participate in the planning and delivery of the program
- co-sponsor the program
- serve as a facility for providing the program.

The practitioner should also emphasize to churches the benefits they will gain by participating in the program and how the program fits with their mission as a whole. For example, the program planner may want to explore with church representatives the linkages between good physical health and good spiritual health.

As with other community organizations, the program planner must carefully research the governing and informal power structure of the churches with which he or she attempts to form alliances. These may differ from church to church as well as from denomination to denomination. While it is always best to obtain formal endorsement from the minister, there are some cases in which support for the program must be gained from others within the church also. For example, the minister may be too busy to participate in the program. In some cases, the minister resides outside of the community and does not have a long history with the church, so support should be obtained from key individuals in addition to the minister. In

many cases, sub-groups or committees will exist which have mechanisms in place for providing similar services and will thus be ideal partners in health promotion efforts. However, churches will differ, so the program planner needs to make an effort to learn more about the formal and informal power structure to know who to approach. Some of the key players one might wish to involve might include Deacons or Trustees, the minister's wife, the head of the church health committee or other committees, the church missionary society, or the church mothers.

In addition to working through a single church, the planner might consider working through local church associations or conferences. This is a way to reach pastors who might not be available in the community during weekdays, as well as a way to gain access to several pastors at the same time.

Most of all, the program planner needs to be willing to put much time and effort into forging alliances with churches. There may be resistance from some who perceive social services as outside the role of the church. With the exception of the minister, who necessarily has many commitments, most participation within the church is voluntary, and active involvement in a health promotion program may be limited by time considerations. The church may also lack the resources to participate as a major player in providing the program. Finally, many service agencies have begun to recognize the importance of churches in delivering services to the elderly, and church members who have been receptive to assisting other agencies may have reached a point of saturation. Being aware of these and other difficulties and being prepared to be patient and persistent will enhance chances of success of the program.

Step 7: Evaluation

Evaluation is a necessary component of any program, particularly given the increased demands for accountability. Not only does evaluation serve to monitor the effectiveness of the program, it also aids in the planning of future programs. The objectives and the strategies chosen will influence to a great extent the type of evaluation needing to be done. While there are many different ways to evaluate a program, some of the more common questions an evaluation component might address include the following:

- How many people participated?
- What activities were accomplished?
- What benefits did the participants experience?

- Was the program cost-effective?
- Were desired changes in participant behavior observed?
- Were objectives met and, if not, why not?

All evaluation data that are obtained should be monitored on a regular basis by the program planner, advisory committee, and any other relevant staff or committees. If a program is not proceeding as expected, the evaluation can provide information that will enable the program objectives, activities or implementation to be modified.

Evaluation begins in the planning phase with the establishment of measurable goals and measurable objectives and the identification of activities to obtain these desired goals. Evaluation needs to be an ongoing process throughout the program so changes can be made periodically throughout the program as well as at the end. Information gathered can be used for recommendations for future programs.

COMPONENTS OF A SUCCESSFUL HEALTH PROMOTION PROGRAM

While the specifics of a program will vary, the successful health promotion program for rural black elders will contain eight components that address the following:

1. **Needs Assessment.** The program planner needs to be aware of what the target population perceives as important concerns and how they would like to address those needs. Actual and perceived needs may differ from community to community because of the heterogeneity of the population. Taking the time to develop a profile of the population will enhance the program's chances for success. Suggested means for getting this profile are found in an Appendix on Needs Assessment Tools.

2. **Community Network/Outreach.** Programs need to be integrated into the community structure. Not only will participation be greater, the feeling of ownership in the program provided to community members will enhance the chances of long-term commitment to the program by the community.

   Allow agencies and organizations trusted by the rural black elders to co-sponsor the program. The roles of these organizations can range from simple endorsement to participation in decision-making. Whatever the level of their

involvement, the credence lent by the agency or organization will provide the target population with a sense of familiarity.

Utilize respected members of the community. Include them in advisory or other committees and utilize their expertise as key informants in the community analysis and needs assessment processes. If the leaders are willing, they can also prove invaluable in outreach and promoting the program through word-of-mouth and other means.

3. **Evaluation.** To ensure the success of the health promotion effort, put into place an ongoing evaluation component. Continuous feedback from the program participants and other key individuals will allow the program planner to make adaptations that update and improve the effectiveness of the program.

4. **Location.** Agencies and organizations have often expected the target population to come to them, rather than reaching out into the community. Deliver the program in locations that are familiar to the rural black elderly and, wherever possible, located in their own neighborhoods. Not only will the hesitancy felt by potential participants be minimized, the sincerity of the program planner's efforts will be recognized.

5. **Commitment.** Because of the unique circumstances of the rural black elders, the elements of a successful health promotion program cannot be expected to be put into place overnight. Building a community network and gaining the trust of the target population is a process that may take considerable time. Be prepared to spend time establishing a network and then maintaining it. If the initial efforts are not successful, do not give up. Utilize evaluation and other feedback to alter the program if necessary. Expect that the informality and personalized communication practices within the community may cause a program to pick up momentum over time.

6. **Presenter Characteristics.** The practitioner who will actually deliver the program to the rural black elders needs to respect the uniqueness and richness of the group. He or she should be able to communicate well and relate to others on a variety of different levels in order to be heard by the wide variety of participants in the program.

   The practitioner needs to remain open-minded and be forward-looking. If the presenter is open to new ideas and willing to take risks, he or she will be able to better deal with the circumstances of the program and the participants as they change over time.

In ideal circumstances, the program presenter will be of the same cultural background and integrated into the local community. Practitioners from the same community will be able to understand language and cultural differences unique to that community. While individuals from different cultural backgrounds may have overcome their own stereotypes, the biases of the target population may still remain and inhibit the ability of such presenters to effectively deliver the program.

Many program planners have found it useful to utilize trained volunteers to do the actual delivery of the program. Using volunteers from the same peer group has certain advantages. In addition to ensuring that the presenter is from the same cultural background and familiar with the community, the peer approach indicates to the participants that others similar to themselves see health promotion as valuable. The trained peers (often called **peer educators**) may face some of the same health problems and can indicate to the participants, "If I can do it, you can do it."

7. **Culturally relevant materials and programs.** Curricular materials need to reflect the preferences and needs of the target population. Where appropriate materials do not already exist, the program planner will want to adapt existing materials or develop new ones.

   Language preferences and reading levels need to be taken into account. Written handout materials are more effective if they reflect local language patterns and are written at a level appropriate to that group. If extremely low literacy is a problem, substitute audiovisual aids and pictorial displays for written materials.

   The delivery of the program is improved if it reflects the belief systems and values of the target population. Be aware of the informal support systems available to the rural black elderly and incorporate them into the program process. In addition to considering the respite and childcare needs of the potential participants, look into multi-generational and extended family approaches to program delivery. Consider including other family members as participants and using their participation to strengthen support for behavioral change of the elders.

   Be prepared to deal with cultural health practices and acknowledge the role which folk healers and root doctors play in the lives of some elderly.

   Integrate health promotion activities into typical activities enjoyed by the rural black elderly, such as church attendance. Recognize the values placed on social time and informality by the elders and incorporate these into the program. (See Part III on delivery techniques for specific examples)

8. **Minimizing barriers to the program.** Some of the barriers to participation were discussed in Part One of the guide. Consider ways to overcome the barriers outlined below, in addition to those discussed in Part One.

   - Work to reduce the feeling of powerlessness over one's health that is so prevalent. Nearly all people believe their health lies beyond their control.

   - Address transportation issues. Transportation is often a barrier to participation, particularly in rural areas where public transportation systems rarely exist. Arrange for transportation to be provided to programs through the use of volunteers or cooperation with other agencies that have transportation systems in place. Consider providing health promotion in conjunction with other activities such as evening bible study where the elders will have already arranged for transportation.

   - Conduct the program in easily accessible facilities that are barrier free and familiar to the target population.

   - Offer health promotion at no cost whenever possible.

   - Use terminology that is familiar to the target population and has no negative associations. Certain clinical terms such as depression or wellness may not be familiar to the target population and lack of understanding of their meaning, or stigmas attached to these terms may inhibit participation. Where fatalism is a part of the belief system, elders often associate health promotion with promoting the self over others. Certain elders feel that control over their own health is out of their hands and to try to exert such control takes from them the important task of serving God through serving others. Make an effort to equate physical health with spiritual health in the minds of the elders.

   - Ensure that the individual or individuals delivering the program can relate to the group. Where possible use peer educators or presenters that come closest to matching the cultural nature of the audience.

PART THREE

HEALTH PROMOTION DELIVERY TECHNIQUES

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When the program is actually ready for presentation, the style of that presentation then becomes important. The following suggestions consist of tips by practitioners that have been found to be useful to them in working with rural black elders.

- **The participants will learn best in a setting that is informal.** The more personal the setting and the more support and trusting relationship that is developed, the more likely it will be that participants will change their behavior.

- **Sessions based on a classroom model will not be as effective as those that incorporate the cultural values of social time and food.** Always allow for the group to mingle socially and get to know one another. Arrange for refreshments to be served. Individuals may attend at the initially because food will be available, but may become active as they recognize the merits of the health promotion program over time.

- **Demonstrate awareness and appreciation of the cultural heritage of the group by providing appropriate foods, music, and materials which do not contain pictures of whites only.** Recognize important holidays and events such as Martin Luther King, Jr. Day (January 15) and Black History Month (February).

- **Clearly outline the benefits that elders will obtain by participating in the program or activities.** Elders learn better when the objectives and relevance of the material are understood.

- **Follow-up is important in programs that emphasize behavioral change.** The practitioner may be suggesting modifications in lifestyle that go against a lifetime of habit and preferences.

- **Emphasize to the participants that it is okay to backslide once in a while.** For example, if a nutrition program urges lower salt intake and lower fat consumption, let them know that the benefits of changes will not be lost if they return to their old patterns of eating at family dinners or other special occasions. Recommend and encourage behavioral changes that will be gradual and allow the individual to become accustomed to new patterns as they make further changes. The more drastic and rigid the behavioral change suggested and attempted, the greater is the likelihood for failure. Despite the permission to occasionally backslide, don't deemphasize regular compliance.

- **Recognize their accomplishments and participation.** Make allowances in your budget to provide certificates or other recognition for their participation and achievement. Awards banquets and graduation ceremonies are powerful ways to recognize their successes.

- **Rewards and give-aways increase the attractiveness of the program.** Tie these into the goals and objectives of the program. For example, if a program is on obesity control, provide rewards of low-calorie snack foods for achieving weight reduction goals. Give-aways such as door prizes can also be tied into the program objectives. A program conducted on safety might include a smoke alarm as a door prize. Look to area merchants to donate items to keep program costs down. Limit the items asked for and do not continually make requests of the same merchants. Give ample publicity to the cooperating merchants in exchange for his contributions. Their participation strengthens community ownership in the program.

- **Involved learning improves retention.** Whenever possible, use hands-on demonstrations and workshops. For example, prepare foods in a nutrition class or have everyone bring assigned dishes from home for a tasting party.

- **Where appropriate, assign simple homework.** Homework will improve the retention level of the participants and reinforce behaviors. For example, participants in a medication education program might be asked to go home and write down the names of all the prescription medications they have in their home as a way of highlighting to them their medication use.

- **It is important to combine programs with popular leisure activities.** This might include allowing times for games or arts and crafts. Competitive games may prove useful in encouraging participation by males.

- **Activities involving music and, with some elders, dancing, are often popular.** Exercise programs put to gospel music have proven highly successful in some black communities.

- **Be aware of days or times that may affect older adult participation.** Programs scheduled on the day Social Security checks arrive will have lower attendance levels. Certain nights during the week may be regular times for church or other civic activities. Programs scheduled during the afternoon may be less successful if a large proportion of the local elders regularly watch soap operas.

- **Pay attention to temperature control and ventilation.** Some elderly tend to be less adaptable to changes or extremes in temperature. They also have less stamina and strength, and tire easily. Seating should be comfortable, and maximum session lengths of one hour are recommended. It is often helpful to announce at the beginning that the program will last one hour, and that during the hour there will be a ten minute break and five minutes to reseat.

- **Many elderly experience sight and/or hearing impairment.** Compensation for visual problems can be made by providing adequate lighting and by using visual materials that are simple and offer maximum contrast. Black print on yellow or white paper is most easily read. All displays or projections should use large lettering and limit words to ten or less. Layout which allows for as much white space as possible is more attractive. Sessions conducted by a presenter speaking in a low-pitched voice with clear enunciation will benefit hearing-impaired participants. Also, planning activities in small groups will put the leader and materials closer to the audience and will enhance visual and oral communication.

- **Visuals and pictorial displays should include persons or activities familiar and relevant to the target population.** Rural black elders will find it difficult to identify with pictures of white middle-class elders exercising on the deck of a cruise ship.

- **To compensate for high illiteracy rates, the presenter should keep in mind that less is more and focus on only the critical information to be conveyed.** Simple memory devices to help the participants remember key points should be utilized. Allow for feedback by encouraging the participants to enter into discussions and ask questions. Participation in discussions should always be voluntary.

- **Try to prevent misunderstanding by using simple vocabulary and by using as few technical words as possible.** Anticipate words which might be unclear or subject to interpretation and be prepared to explain them. If it is not clear whether a word is understood by the group, stop and ask if there are any who would like to be reminded what the word means.

- **Be aware of the proper ways to address individuals.** Assuming the informal system by addressing participants by their first names may be inappropriate. What one intends to be informal and friendly can be interpreted as condescending or rude, and in some cases racist. This issue can be touchy, but there are many practitioners who regularly use first names to address all participants and who have had no problems.

- **Never force participants to provide personal information or speak before the group unless willing.**

- **Make a list of participants and, with their permission, distribute it among the group.** This practices can stimulate interaction among the group during breaks and between sessions.

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HEALTHSTYLE

A Self-Test

This brief test (one kind of "needs assessment" instrument) can help those working in the health promotion field to quickly identify lifestyle factors that may be putting individuals at risk. It is not intended to replace in-depth medical information, but rather provides six scores that can guide practitioners to the areas where education and behavior changes are most needed to promote good health in one's own community.

Directions for Use:

Giving the test: This test may be given out in a group setting or individually to persons.

Individual testing: This survey may be handed out to individuals to complete and return to you. It may also be read to those who have difficulty reading by giving them instructions to circle the answer that applies to them. The large print and pictures on each set of questions will make it easy for the elder to follow along and circle the appropriate answer.

Group testing: This survey may be handed out to a group meeting with instructions for each person to complete the questions privately, calculate their scores, and then turn in the forms for you to aggregate the scores and determine the community needs. The test is also designed to present orally to a group by passing out the questions, reading aloud one section at a time and asking the elders to circle the appropriate answers. Large print and pictures are designed to assist them in seeing where to circle, and what section you are reading, if they are unable to read. If your judgement is that persons are willing to be public about their responses, you may ask for a show of hands for each question and response, and then note the principal response to each question as a means of assessing where the majority of persons in the audience are on each health question.

Scoring the test: Each of the six sections of the test should be scored separately. Consider the test to be a six part test, in which each of the six parts constitutes a form of assessment for different areas of health. The scores of each of the six parts is **not** to be summed into one grand score; each part of the survey is to be looked at and considered separately. By using the "What Your Scores Mean to YOU" page, you can help them in interpreting their own scores. This is an important step in their self-awareness of potential health problems that they can work on.

It is best if the participants can do their own scoring and use the scores as part of a self-assessment process. As leader of the group, you should collect all questionnaires and scores after each person has calculated their own scores and you have discussed the meaning of each score with the group. You can make the best use of the scores if you make a tally of them to determine the areas of greatest need within the community. The more people you can get to complete the self-assessment form the better you will be able to accurately assess your community's health problems.

AN UNATTACHED IDENTICAL COPY OF THE HEALTHSTYLE TEST HAS BEEN INCLUDED FOR DULICATING PURPOSES.

• • •

This test was adapted from an original distributed by the National Health Information Clearinghouse, P.O. Box 1133, Washington, D.C. 20013; it is not copyrighted and may be freely reproduced, distributed, and used by persons interested in assessing health practices in their locality.

HEALTHSTYLE
a self-test

CIGARETTE SMOKING

If you <u>never smoke</u>, enter a score of 10 for this section and go to the next section on Alcohol and Drugs.

	Almost Always	Sometimes	Never
1. I try not to smoke cigarettes.	2	1	0
2. I smoke only low tar and nicotine cigarettes or I smoke a pipe or cigars.	2	1	0

Smoking Score: _____

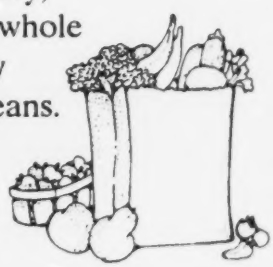
ALCOHOL AND DRUGS

	Almost Always	Sometimes	Never
1. I do not drink alcohol or I drink no more than 1 or 2 drinks a day.	4	1	0
2. I do not drink alcohol or take illegal drugs to deal with problems in my life.	2	1	0
3. I am careful not to drink alcohol when taking certain medicines (for example, medicine for sleeping, pain, colds, and allergies).	2	1	0
4. I read and follow the label directions when taking prescriptions and over-the-counter drugs.	2	1	0

Alcohol and Drugs Score: _____

EATING HABITS

	Almost Always	Sometimes	Never
1. I eat a variety of foods each day, such as fruits and vegetables, whole grain breads, lean meats, dairy products, and dry peas and beans.	4	1	0
2. I limit the amount of fat I eat by cutting off extra fat on meats, and eating very little butter, cream, shortenings, and organ meats such as liver.	2	1	0
3. I limit the amount of salt I eat by cooking with only small amounts, not adding salt at the table, and avoiding salty snacks.	2	1	0
4. I try not to eat too much sugar (especially frequent snacks of sticky candy or soft drinks).	2	1	0

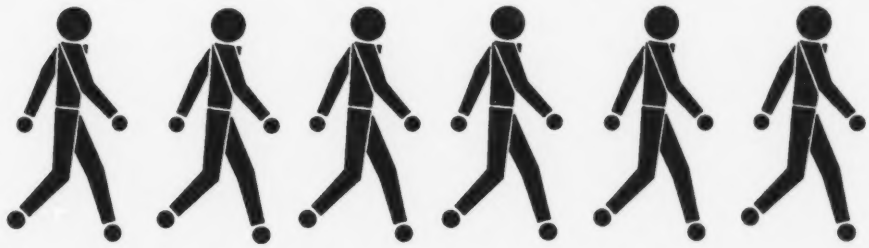


Eating Habits Score: _____

EXERCISE/FITNESS

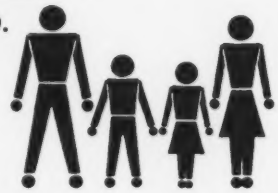
	Almost Always	Sometimes	Never
1. I keep my weight under control. I am not overweight or underweight.	3	1	0
2. I do heavy exercises for 15-30 minutes at least 3 times a week (examples include running, swimming, brisk walking).	3	1	0
3. I do other exercises that help keep my muscles tight for 15-30 minutes at least 3 time a week (examples include aerobics, jumping jacks, sit ups, etc.).	2	1	0
4. I use part of my spare time doing things that are fun and give me exercise at the same time (such as walking, dancing, working in my garden).	2	1	0

Exercise/Fitness Score: _____



STRESS CONTROL

	Almost Always	Sometimes	Never
1. I enjoy myself at my job or when I'm doing other work.	2	1	0
2. I find it easy to relax and express my feelings freely.	2	1	0
3. I try to avoid stress as much as I can.	2	1	0
4. I have relatives or friends I can talk to about personal matters and can ask them for help.	2	1	0
5. I join in group activities (such as church and community organizations) or I have hobbies that I enjoy.	2	1	0



Stress Control Score:_____

SAFETY

	Almost Always	Sometimes	Never
1. I wear a seat belt while riding in a car.	2	1	0
2. I do not drive when I've been drinking alcohol or taking medicine.	2	1	0
3. I obey traffic rules and the speed limit when driving.	2	1	0
4. I am careful when using such things as cleaners, bug sprays, paint, electrical devices and tools.	2	1	0
5. I do not smoke in bed.	2	1	0

Safety Score: _____

What Your Scores Mean to YOU

Scores of 9 and 10

Excellent! Your answers show that you are aware of the importance of these areas to your health. More important, you are putting your knowledge to work for you by practicing good health habits. As long as you continue to do so, these areas should not pose a serious health risk. It's likely that you are setting an example for your family and friends to follow. Since you got very high scores in these areas, you may want to consider other areas where your scores indicate room for improvement.

Scores of 6 to 8

Your health practices in these areas are good, but there is room for improvement. Look again at the items you answered with a "Sometimes" or "Almost Never". What changes can you make to improve your score? Even a small change can often help you achieve better health.

Scores of 3 to 5

Your health risks are showing! Would you like more information about the risks you are facing and about why it is important for you to change these behaviors. Perhaps you need help in deciding how to successfully make the changes you desire. In either case, help is available.

Scores of 0 to 2

Obviously, you were concerned enough about your health to take the test, but your answers show that you may be taking serious and unnecessary risks with your health. Perhaps you are not aware of the risks and what to do about them. You can easily get the information and help you need to improve, if you wish. The next step is up to you.

RESOURCE CENTERS

The following list of organizations - both public and private - offers the practitioner quick technical information and help in various aspects of health education. Most have 800 phone numbers that are accessible weekdays between 9:00 a.m. and 5:00 p.m. (local time). Practitioners are encouraged to familiarize themselves early in their planning process with the broad array of organizations and information services that are available, and to use them freely. It is also suggested that practitioners make up a comparable list of local resources. Many of these centers have publication lists, free pamphlets, and other publications that are free in limited quantities, or modestly priced.

Some of the centers are specialized, such as the American Kidney Fund. Others are very broad based and can provide general information. Note particularly the following organizations that are listed on the following pages:

Center on Rural Elderly
National Council on the Aging
National Resource Center on Health Promotion and Aging (AARP)
Office of Disease Prevention and Health Promotion
Health Information Center (ODPHP)
Office of Minority Health Resource Center

RESOURCE CENTERS

Age Base, The Brookdale Foundation Group
126 East 56th Street
New York, NY 10022-3668
(212) 308-7355

Age Base is a national computerized clearinghouse of direct service programs for the elderly for use by professionals, aging organizations, and foundations. The Age Base database contains referral and basic descriptive information on health promotion programs nationwide.

American Association of Retired Persons (AARP)
Health Advocacy Services (HAS)
1909 K Street, NW
Washington, DC 20049
(202) 728-4796

The Health Advocacy Services Section of AARP works with volunteers and other professional organization to develop and implement health promotion materials and programs for older people. Health promotion programs, publications, and training materials are available through HAS.

American Council of the Blind
(202) 393-3666 (in Washington, DC)
(800) 424-8666

Offers information on blindness. Provides referrals to clinics, rehabilitation organizations, research centers, and local chapters. Also publishes resource lists.

American Diabetes Association
(703) 549-1500 in VA and DC metro area
(800) 232-3472

Provides free literature, newsletter, and information on health education and support group assistance.

American Foundation for the Blind (AFB)
(800) 232-5463

Gives information on visual impairments and blindness and on AFB services, products and publications.

American Kidney Fund
(800) 492-8361 (in Maryland)
(800) 638-8299

Grants financial assistance to kidney patients who are unable to pay treatment-related costs. Also provides information on organ donations and kidney-related diseases.

American Mental Health Fund
(800) 433-5959
(800) 826-2336 (in Illinois)

Makes available via recorded message the AMHF pamphlet that includes general information about the organization and mental health and warning signs of mental illness.

American Red Cross
17th & D Streets, NW
Washington, DC 20006
(202) 737-8300

The various Red Cross chapters across the country sponsor wellness activities for older adults, such as the "Health Series for Senior Citizens" sponsored by the Pittsburgh-Allegheny County Chapter and the "Wisdom Project" of the Greater New York Chapter. Both are modular serials of health education covering a variety of topics on common health problems faced by the older adult. They publish *Red Cross News* monthly, and a variety of other service-related books and materials.

Cancer Information Service
National Cancer Institute
Blair Building, Room 414
9000 Rockville Pike
Bethesda, MD 20892
(301) 427-8656 (in Maryland) or
(800) 4-CANCER, Hawaii call (800) 524-1234

Provides cancer information to patients and their families and the general public. Distributes National Cancer Institute publications.

Center for Medical Consumers and Health Care Information
237 Thompson Street
New York, NY 10012
(212) 674-7105

The center encourages people to make a critical evaluation of information received from health care professionals and to show people that life-style choices regarding smoking, exercise habits, and nutritional practices are vital components to healthy living. It publishes a monthly monograph, *Health Facts.*

Center on Rural Elderly
5245 Rockhill Road
University of Missouri-Kansas City
Kansas City, MO 64110
(800) 235-1000

The Center offers a Directory of Health Education Programs for Elders, describing 37 health promotion programs designed for older persons. It also has a data base with information on major organizations and persons working in health promotion, and information on health education resource materials.

Combined Health Information Database (CHID)
National Diabetes Information Clearinghouse
Box NDIC
Bethesda, MD 20892
(301) 468-2162

Provides health information and information on health education/health promotion resources to professionals. The on-line, publicly accessible database includes sub-files of nine information programs: AIDS school health education, arthritis, diabetes, digestive diseases, health education, health information, high blood pressure, kidney diseases, and Veterans Administration education. The database is available on-line through BRS Information Technology; call (800) 345-4277.

Consumer Information Center
Pueblo, CO 81009

Distributes consumer publications on topics such as education, food and nutrition, health, exercise, money management Federal benefits, and weight control. The Consumer Information Catalog is available free from the center at the above address.

Consumer Product Safety Commission
(800) 492-8104 (in Maryland)
(800) 492-CPSC

Answers questions and provides material on consumer product safety, including product hazards and product defects, injuries sustained in using products. Covers only products used in and around the home, excluding automobiles, foods, drugs, cosmetics, boats, and firearms.

Food and Nutrition Information Center
National Agricultural Library
Room 304
Beltsville, MD 20705
(301) 344-3719

Serves the information needs of professionals, students, and consumers, interested in nutrition education, nutrition science, food service management, food science, and food technology. Students and consumers are encouraged to contact local resources such as their local cooperative extension agency, health departments, and public and university libraries before calling the center.

Healthwise, Inc.
P.O. Box 1989
Boise, ID 83701
(208) 345-1161

Healthwise researches and develops health promotion programs for use by organizations and individuals. Healthwise distributes two comprehensive, evaluated health promotion programs for older people, "Growing Younger" - a physical wellness program - and "Growing Wiser" - a mental wellness program - as well as many other books and programs on health promotion.

Hearing Helpline
(703) 642-0580 (in Virginia)
(800) 424-8576

Provides information on better hearing and preventing deafness. Materials are mailed on request. A service of the Better Hearing Institute.

Heartlife
(404) 523-0826 (in Georgia)
(800) 241-6993

Answers questions on heart disease and pacemakers and distributes a quarterly periodical entitled *Pulse*.

Hospice Education Institute
Hospicelink
(203) 767-1620 (in Connecticut)
(800) 331-1620

Offers general information about hospice care and makes referrals to local programs. Does not offer medical advice or personal counseling.

Information Center for Individuals with Disabilities
20 Park Plaza, Room 330
Boston, MA 02116
(617) 727-5540

The center assists individuals with disabilities in learning about the appropriate resources, agencies, and facts that promote a more independent life-style. It gathers and stores information in subject categories, including architectural accessibility, employment, equipment, housing, law, personal care, recreation, and travel. It collects and cross-references data on more than 1,000 state, federal, public, and private agencies that help the disabled. It publishes monthly *Fact Sheets*, *Together* (a monthly newsletter), and resource manuals.

National Arthritis and Musculoskeletal and Skin Diseases
Information Clearinghouse
P.O. Box AMS
Bethesda, MD 20892
(301) 468-3235 or
(800) 283-7800

Distributes information to health professionals and consumers. Identifies materials concerned with arthritis and musculoskeletal and skin diseases and serves as an information exchange for individuals and organizations involved in public, professional, and patient education. Refers personal requests from patients to the Arthritis Foundation.

National Association for Sickle Cell Disease
(213) 936-7205 (in California)
(800) 421-8453

Offers genetic counseling and an information packet.

National Center for Health Promotion and Aging
c/o National Council on the Aging, Inc.
600 Maryland Avenue, SW, West Wing
Washington, DC 20024
(202) 479-1200

The National Center for Health Promotion and Aging is a unit of NCOA. It provides information and materials to health care professionals and others interested in developing and implementing health promotion programs for older adults. It offers training and technical assistance in establishing and maintaining health promotion programs for older adults. The center maintains a resource library and media center on health promotion resources for consumers and professionals.

National Cholesterol Education Program Information Center
4733 Bethesda Avenue, Room 530
Bethesda, MD 20814
(301) 951-3260

Provides information on cholesterol to health professionals and the general public.

National Council of Senior Citizens
925 15th Street, NW
Washington, DC 20005
(202) 347-8800

The council is an educational and advocacy group that supports improved recreational, educational, and health programs; increased voluntary service programs; better housing; and other programs to aid older adults. It sponsors educational workshops and leadership

training institutes in addition to organizing and developing various programs for other groups. It distributes films, special reports pertinent to the economic and medical care needs of the elderly, and legislative bulletins. It publishes a monthly journal, *Senior Citizen News.*

National Council on the Aging, Inc. (NCOA)
600 Maryland Avenue, SW, West Wing 100
Washington, DC 20024
(202) 479-1200

NCOA is a national professional organization working to promote the concerns of older people. A number of publications, many in the area of health promotion, are available from NCOA.

National Diabetes Information Clearinghouse
Box NDIC
Bethesda, MD 20892
(301) 468-2162

Collects and disseminates information to consumers and health professionals on diabetes and its complications, planning and implementing educational programs, and evaluating educational materials. Maintains an automated file of educational materials on the Combined Health Information Database.

National Digestive Diseases Information Clearinghouse
P.O. Box NDDIC
Bethesda, MD 20892
(301) 468-6344

Provides information on digestive diseases to health professionals, patients, and their families.

National High Blood Pressure
Education Program Information Center
4733 Bethesda Avenue, Room 530
Bethesda, MD 20814
(301) 951-3260

Provides information on the detection, diagnosis, and management of high blood pressure to consumers and health professionals.

National Institute of Senior Centers (NISC)
c/o National Council on the Aging, Inc.
600 Maryland Avenue, SW, West Wing 100
Washington, DC 20024
(202) 479-1200

NISC assists senior centers, organizations, and communities in developing new centers and upgrading existing operations. It promotes professionalism among those working in senior centers and develops standards for senior centers nationwide. It conducts seminars and workshops and provides management training for students working with senior centers. Publications include *Senior Center Report* (bimonthly newsletter) and *Senior Center Standards: Guide to Developing and Managing Senior Centers.*

National Resource Center on Health Promotion and Aging
AARP
1909 K Street, NW, 5th Floor
Washington, DC 20049
(202) 728-4476

The National Resource Center supports the aging and health network in the development and implementation of health promotion programs for older people. The Center maintains a clearinghouse of information on health promotion programs and materials distributed by federal, state, local, and private organizations. The clearinghouse may be accessed by phone or mail. The Center is funded (in part) by a grant from the Administration on Aging.

National Senior Sports Association
317 Cameron Street
Alexandria, VA 22314
(703) 549-6711

The association helps older Americans improve and maintain physical and emotional well-being through organized sports and recreation. It conducts regional and national senior tournaments in golf, tennis, and bowling. It publishes a monthly magazine, *Senior Sports News.*

National Voluntary Organizations of Independent Living for the Aging
600 Maryland Avenue, SW, West Wing 100
Washington, DC 20024
(202) 479-1200

This constituent organization of the National Council on the Aging emphasizes in-house and community-based health and social services to help older persons remain in, or return to, their homes and live independently, and works to educate and assist voluntary organizations to help develop such services. It encourages cooperation between voluntary organizations and the public and provides a forum for organizations, government agencies, and consumer groups to share ideas and develop a network of services for the aged. Publications include a service quarterly monograph, *Update on Aging for the Voluntary Sector; Directory of National Voluntary Organizations: A Resource for Services to Aging;* and other materials to help organizations for the aging develop programs.

ODPHP Health Information Center
P.O. Box 1133
Washington, DC 20013-1133
(202) 565-4167 (in Maryland) or
(800) 336-4797

The ODPHP Health Information Center was established in 1979 by the Office of Disease Prevention and Health Promotion (ODPHP). The center helps the public and health care professionals locate health information through identification of health information resources, an information and referral system, and publications. The data base is accessible to the public through DIRLINE, part of the National Library of Medicine's MEDLARS system. Publications available through the center include *Health Finders,* a series of resource lists on current health concerns; *Health Information Resources in the Federal*

Government; Locating Funds for Health Promotion Projects; and *Staying Healthy: A Bibliography of Health Promotion Materials.* It also publishes a health finder called *Exercise for Older Americans.*

Office of Disease Prevention and Health Promotion (ODPHP)
Department of Health and Human Services (HHS)
Mary E. Switzer Building, Room 2132
330 C Street, SW
Washington, DC 20201
(301) 565-4167 (in Maryland) or
(800) 336-4797

The Office of Disease Prevention and Health Promotion is the unit in HHS for policy development and coordination of activities related to disease prevention, health maintenance, and the promotion of sound health practices. The office offers publications on federal programs and policy, community and school health promotion programs, work-site health promotion, education of health professionals, health promotion activities in health maintenance organizations, and nutrition. It is also responsible for he operation of the Health Information Center. Its publications are available through the National Health Information Clearinghouse, or the National Technical Information Service. ODPHP also sponsors the Healthy Older People Program, a public campaign to educate people about health practices that can reduce risks of disabling illness and increase their prospects for more productive, active lives.

Office of Minority Health Resource Center
P.O. Box 37337
Washington, DC 20013-7337
(800) 444-6472

Responds to consumer and professional inquiries on minority health-related topics by distributing materials, providing referrals to appropriate sources, and identifying sources of technical assistance. Coordinates a network of professionals active in the field of minority health and related areas. Staff are available Monday through Friday, 9 AM to 5 PM (EST) to respond to Spanish and English inquiries. The Center also maintains a Resource Persons Network (RPN) of select health professionals who have volunteered to help minority community-based organizations; it also operates a data base of new studies, model programs, and innovative research.

Office of Substance Abuse Prevention
(301) 443-6500 (in Maryland) or
(800) 638-2045

Offers information and technical assistance to schools, parent groups, business and industry, and national organizations in developing drug abuse prevention activities. Does not provide crisis counseling, intervention treatment referral, information on the pharmacology of drugs, or on the criminal aspects.

President's Council on Physical Fitness and Sports (PCPFS)_
Department of Health and Human Services (HHS)
405 Fifth Street, NW, Suite 7103
Washington, DC 20001
(202) 272-3430

Cooperates with government and private groups to promote the development of physical fitness leadership, facilities, and programs. PCPFS also works with various organizations on program design and implementation and offers a variety of testing, recognition, and incentive programs. Materials are available on exercise; physical fitness for youth, adults, and the elderly; jogging; walking; and aquadynamics. It publishes the bimonthly *President's Council on Physical Fitness and Sports Newsletter* and *Physical Fitness/Sports Medicine*, a quarterly bibliography.

RESOURCE MATERIALS

The following list represents a selection of printed materials useful for practitioners who are developing health promotion programming in their community. The list is selective: it represents only a small fraction of available materials. Most of the materials are free, though some of the listings have nominal charges. When contacting the source, ask for their publication list which may lead to other useful materials.

Don't Miss Out On Your Sunset Years (Poster)

Provides basic information about colon cancer. Focuses on 63 year-old Sam, whose prospects for retirement are clouded by this disease. He and his wife, Loretta, learn about the symptoms of colon and rectal cancer and the treatments available. Single copy free; order # 2124.

Source: American Cancer Society
3340 Peachtree Road, NE
Atlanta, GA 30026
(404) 320-3333; (800) 227-2345

Got a Few Minutes? (Pamphlet)

Focuses on Black women. Illustrates the importance and the simplicity of self-examinations for breast cancer. Recommends monthly self-exams beginning in the early teen years, and outlines the basics of the procedure. Discusses mammography, which can detect lumps too small to be found by hand, and cancer's seven warning signals. Single copy free; order # 2078.

Source: American Cancer Society
3340 Peachtree Road, NE
Atlanta, GA 30026
(404) 320-3333; (800) 227-2345

Good News for Blacks About Cancer (Pamphlet)

Presents general information on cancer, such as causes, methods of prevention, and the importance of early detection. This pamphlet also highlights the factors that affects Black Americans at a disproportionate rate. Stresses the importance of eating healthfully and not using tobacco. Includes a table of early-warning signals for both men and women. (color). Single copy free.

Source: Office of Cancer Communications,
National Cancer Institute
Building 31, Room 10A-18
9000 Rockville Pike
Bethesda, MD 20892
(800) 433-6237

Diabetes Among Blacks (Fact Sheet)

Explains the types of diabetes; the impact of diabetes on Blacks; diabetes complications; warning signs of he disease, and where to get information. Free

Source: American Diabetes Association, Inc.
National Service Center
1660 Duke Street
Alexandria, VA 22314
(703) 549-1500

Noninsulin-Dependent Diabetes (Booklet)

Presents general information on diabetes, such as causes, methods of prevention, how diabetes is treated, diet, exercise, the complications, and how to cope with diabetes. Free.

Source: National Diabetes Information Clearinghouse
Box NDIC
Bethesda, MD 20892
(301) 468-2162; (800) 232-3472

Blacks and High Blood Pressure (Pamphlet)

Presents facts about Blacks and high blood pressure. It discusses what can be done to reduce risk of high blood pressure, and provides important points about treatment. Single copy free.

Source: Alabama Department of Public Health
State Office Building, Room 250
Montgomery, AL 36130-1701
(205) 261-5128

Small Wonder. Your High Blood Pressure Medicine Can Work Miracles (Poster)

Pictures a pill in the palm of an outreached hand. Encourages people with high blood pressure to take their prescribed medicine every day to reduce the risk of stroke, heart attack, or kidney failure. Available from State and local affiliates. American Heart Association. Order # 62-011-B (LP). Cost information available from affiliates.

Source: American Heart Association
National Center
7320 Greenville Avenue
Dallas, TX 75231
(214) 750-5300

We're Taking Care of Ourselves...(Pamphlet)

Contains quotes from Black Americans encouraging readers to take their blood pressure medication every day, get their blood pressure checked regularly, stay away from greasy foods, go easy on salt, and stay active. Single copy free.

Source: American Heart Association of Greater Miami
5220 Biscayne Boulevard
Miami, FL 33137
(305) 751-1041

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The Facts About High Blood Pressure and Blacks (Pamphlet)

Discusses high blood pressure, its asymptomatic nature, general prevalence among Blacks, contributing factors, and complications that may occur if left untreated. Single copy free.

Source: National Kidney Foundation of Iowa, Inc.
c/o Iowa Lutheran Hospital
East University at Penn
Des Moines, IA 50316
(515) 263-5107

Eating Well to Stay Well

This guide is designed to inform and encourage older adults to eat in a sensible and healthy way. It includes practical applications of the U.S. dietary guidelines and life-style suggestions to maintain health despite existing chronic conditions.

Source: National Council on the Aging
Department 5087
Washington, DC 20061-5087

Health Promotion and Aging - A National Directory of Selected Programs

This monograph provides concrete, illustrative examples of various health promotion and wellness programs for the elderly. It discusses the goals, topics, recruitment, information dissemination, evaluation, and nature of the target population for each of the programs. It also provides a listing of additional resources for designing and implementing health promotion programs for the elderly. Order # 2613: $7/pp

Source: National Council on the Aging
Department 5087
Washington, DC 20061-5087

Healthy Older People Campaign Materials

The "Healthy Older People" campaign is designed to educate older people about health practices that can reduce risks of disabling illness and increase prospects for more productive, active lives. Materials provided include a general information packet, press kits, radio programming modules, posters, and TV public-service announcements. Training materials are available on communicating with older people, developing public education materials, and developing community-based programs. Technical review notes designed to update health professionals on current research, media tips, and health promotion program guidelines on a variety of topics are also available. Presently, review notes on medications, walking events, smoking cessation, and preventive dental care are available, as is a monthly *Program Memo* newsletter that summarizes and updates activities in the "Healthy Older People" campaign.

Source: Office of Disease Prevention and Health Promotion
Healthy Older People
330 C Street, SW
Washington, DC 20201
(800) 336-4797; (202) 429-9091 (in the District of Columbia)

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The "Feeling Great" Wellness Program for Older Adults

This book describes a successful health promotion program for older adults. It contains information and advice on how to involve older adults in activities to improve their physical, emotional, and psychological health. This volume examines an effective program that allows older adults to learn about their health care needs and options, practice a daily exercise program suited to their abilities, develop supportive new friendships, increase their self-esteem, and overcome barriers of ill health, poor diet, sedentary life-styles, and physical and emotional difficulties.

Source: Weiss, J.C
The Haworth Press, Inc., 1988
New York, NY

Nutrition and the Elderly: A Selected Annotated Bibliography for Nutrition and Health Professionals

This bibliography contains an extensive listing of articles, books, research reports, and other materials for nutritionists and health promotion program planners. Information focuses on establishing healthy and nutritious food habits among older adults and the biological and physical aspects of nutrition and aging.

Source: Cox, E. and Sandberg, J.
U.S. Government Printing Office, 1985
Washington, DC

Health Promotion for Older Persons: A Selected Annotated Bibliography

This bibliography provides an extensive listing of articles, books, monographs, research projects, and other materials for professional and laypersons interested in developing a wellness program for older adults. Each citation provides a concise annotation of the article's content, the author, the source, and the date of publication. Order # 2015: $5.50/pp

Source: National Council on the Aging
Department 5087
Washington, DC 20061-5087

Age Pages

This series of fact sheets for a lay audience is printed on two sides in large type. Topics include dental care, safe use of medications, controlling high blood pressure, nutrition, exercise, and foot care. The fact sheets are distributed free by the National Institute on Aging. To order, phone (301) 495-3455.

Healthfinders

This series of resource lists is on current health concerns. Topics include toll-free numbers for health information, vitamins, health risk appraisals, minority health, exercise for older Americans, family health, on-line health information, and women's health. Write to the below address to be put on a mailing list.

Source: ODPHP Health Information Center
P.O. Box 1133
Washington, DC 20013-1133

Pep Up Your Life: A Fitness Book for Seniors

This exercise book was designed to meet the special conditioning needs of older Americans. It provides information on preparing for exercise, warming-up, exercising, nutrition, exercising from a wheelchair, and balance and agility. It gives examples of exercises designed to promote strength, flexibility, and endurance. The exercises are arranged in three levels according to their degree of difficulty. Information is provided on how to do each exercise correctly in order to derive the most benefit from it. Single copy free.

Source: AARP Publications
Program Resource Department/BV
1909 K Street, NW
Washington, DC 20049

Compendium of Health Promotion-related Initiatives for Older Adults

Order # 299 - $2.50 per copy

Source: National Council on the Aging, Inc.
Department 5087
Washington, DC 20061-5087

Health Promotion for Older Persons: A Selected Annotated Bibliography

Order # 2015 - $3.50 per copy

Source: National Council on the Aging, Inc.
Department 5087
Washington, DC 20061-5087

Health Alert Fact Sheets

A series of eight fact sheets on health topics of interest to older adults. Single set free.

Source: National Council on the Aging, Inc.
Department 5087
Washington, DC 20061-5087

Staying Healthy: A Bibliography of Health Promotion Materials

Order # E0002 - $2.00 handling fee

Source: ODPHP National Health Information Center
P.O. Box 1133
Washington, DC 20013-1133

HealthFinder: Community Health Promotion Programs

Order # A0020 - $1.00 handling fee

Source: ODPHP National Health Information Center
P.O. Box 1133
Washington, DC 20013-1133

Locating Funds for Health Promotion Projects

Order # Z0001 - $2.00 handling fee

Source: ODPHP National Health Information Center
P.O. Box 1133
Washington, DC 20013-1133

Healthy Older People General Information Packet

Order # Y0003 - Single copy free.

Source: ODPHP National Health Information Center
P.O. Box 1133
Washington, DC 20013-1133

Healthy Aging - Model Health Promotion Programs for Minority Elders

A 46 minute VHS videotape which includes information on 5 model programs in health promotion for minority elders, and on strategies for developing programs in the community. Available for loan from the National Resource Center on Health Promotion and Aging

Source: National Resource Center on Health Promotion and Aging
AARP
1909 K Street, NW, Fifth Floor
Washington, DC 20049

Healthy Aging - Making Health Promotion Work for Minority Elders

A 20 page booklet which describes health promotion for minority elders, and discusses strategies for planning a program in the community. Includes contact information for national organizations and resources. Can be used in conjunction with the videotape, *Healthy Aging - Model Health Promotion Programs for Minority Elders*, or as a stand-alone piece.

Source: National Resource Center on Health Promotion and Aging
AARP
1909 K Street, NW, Fifth Floor
Washington, DC 20049

The Age Base Directory of Health Promotion Programs for Older Adults

Source: The Brookdale Foundation Group
126 E. 56th Street, 10th Floor
New York, NY 10022
(212) 30[illegible]-7355

Directory of Health Education Programs for Elders

This directory provides detailed information about selected health education programs for the elderly. Included in each program description is an abstract; information about cost, curriculum, implementation, and evaluation; and comments by reviewers regarding community and target audience characteristics, time intensity, content, and adaptations, particularly for rural and minority populations. Program categories are: comprehensive, mental health (including exercise), medication, safety, and consumerism.

Source: Center on Rural Elderly
University of Missouri-Kansas City
5245 Rockhill
Kansas City, MO 64110
(816) 235-2180

HEALTHSTYLE
a self-test

CIGARETTE SMOKING

If you **never smoke**, enter a score of 10 for this section and go to the next section on Alcohol and Drugs.

	Almost Always	Sometimes	Never
1. I try not to smoke cigarettes.	2	1	0
2. I smoke only low tar and nicotine cigarettes or I smoke a pipe or cigars.	2	1	0

Smoking Score: _____

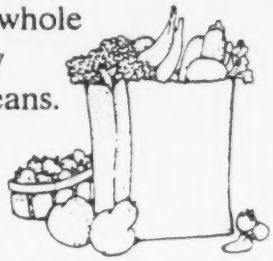
ALCOHOL AND DRUGS

	Almost Always	Sometimes	Never
1. I do not drink alcohol or I drink no more than 1 or 2 drinks a day.	4	1	0
2. I do not drink alcohol or take illegal drugs to deal with problems in my life.	2	1	0
3. I am careful not to drink alcohol when taking certain medicines (for example, medicine for sleeping, pain, colds, and allergies).	2	1	0
4. I read and follow the label directions when taking prescriptions and over-the-counter drugs.	2	1	0

Alcohol and Drugs Score: _____

EATING HABITS

	Almost Always	Sometimes	Never
1. I eat a variety of foods each day, such as fruits and vegetables, whole grain breads, lean meats, dairy products, and dry peas and beans.	4	1	0
2. I limit the amount of fat I eat by cutting off extra fat on meats, and eating very little butter, cream, shortenings, and organ meats such as liver.	2	1	0
3. I limit the amount of salt I eat by cooking with only small amounts, not adding salt at the table, and avoiding salty snacks.	2	1	0
4. I try not to eat too much sugar (especially frequent snacks of sticky candy or soft drinks).	2	1	0

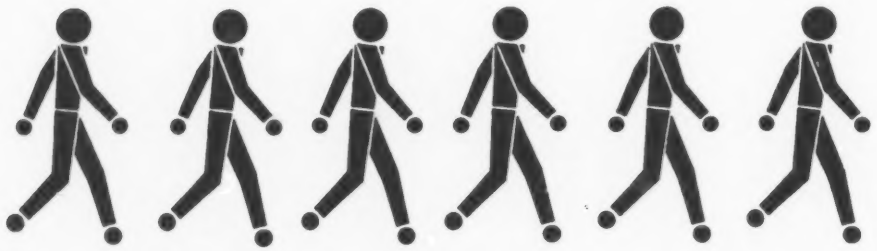


Eating Habits Score: _____

EXERCISE/FITNESS

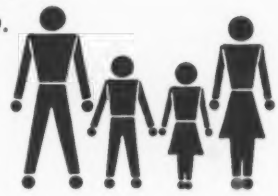
	Almost Always	Sometimes	Never
1. I keep my weight under control. I am not overweight or underweight.	3	1	0
2. I do heavy exercises for 15-30 minutes at least 3 times a week (examples include running, swimming, brisk walking).	3	1	0
3. I do other exercises that help keep my muscles tight for 15-30 minutes at least 3 time a week (examples include aerobics, jumping jacks, sit ups, etc.).	2	1	0
4. I use part of my spare time doing things that are fun and give me exercise at the same time (such as walking, dancing, working in my garden).	2	1	0

Exercise/Fitness Score: _____



STRESS CONTROL

	Almost Always	Sometimes	Never
1. I enjoy myself at my job or when I'm doing other work.	2	1	0
2. I find it easy to relax and express my feelings freely.	2	1	0
3. I try to avoid stress as much as I can.	2	1	0
4. I have relatives or friends I can talk to about personal matters and can ask them for help.	2	1	0
5. I join in group activities (such as church and community organizations) or I have hobbies that I enjoy.	2	1	0

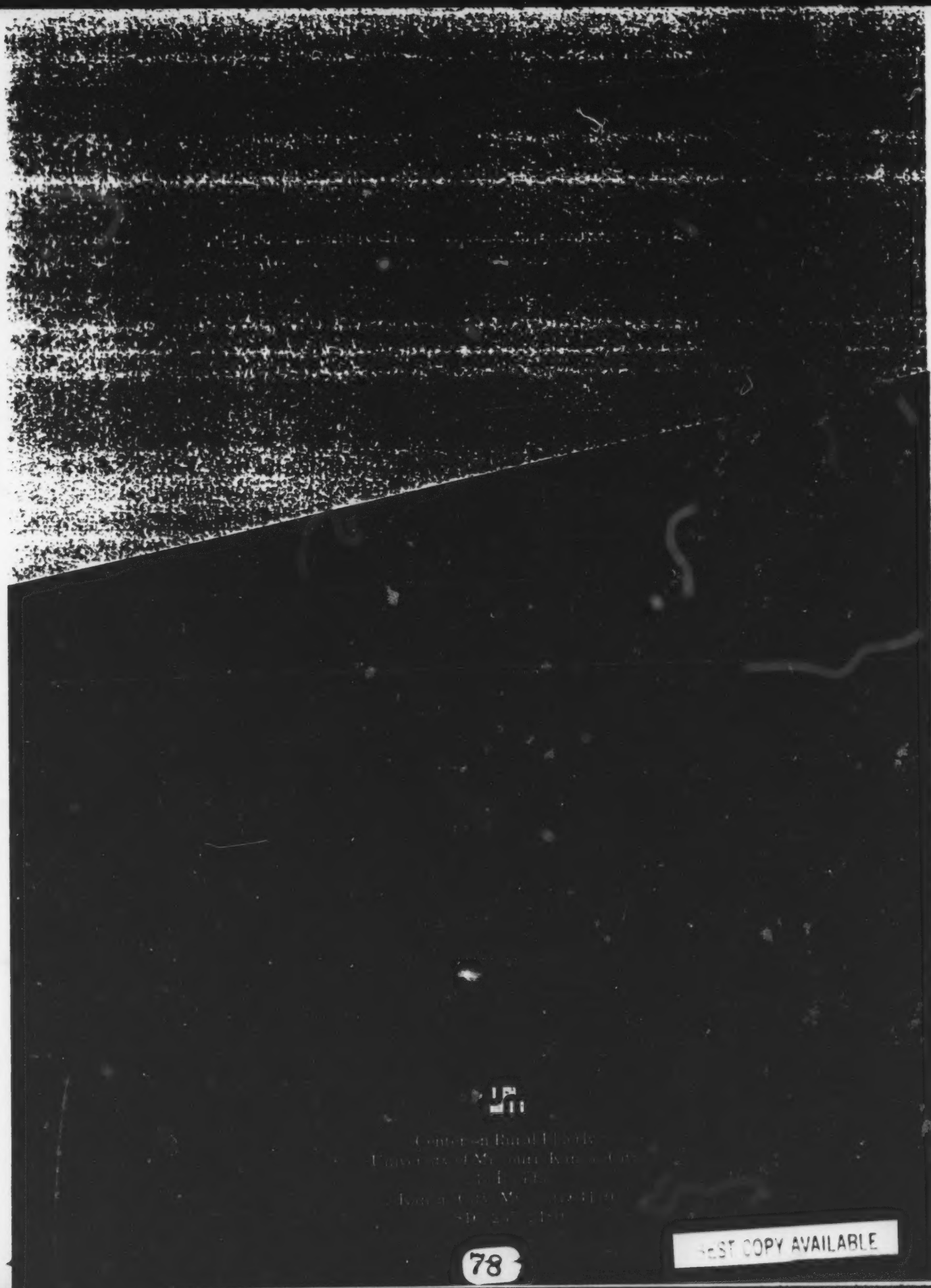


Stress Control Score:_____

SAFETY

	Almost Always	Sometimes	Never
1. I wear a seat belt while riding in a car.	2	1	0
2. I do not drive when I've been drinking alcohol or taking medicine.	2	1	0
3. I obey traffic rules and the speed limit when driving.	2	1	0
4. I am careful when using such things as cleaners, bug sprays, paint, electrical devices and tools.	2	1	0
5. I do not smoke in bed.	2	1	0

Safety Score: _____



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